TUBERCULOSIS PREVENTION AND CONTROL PROGRAM

4150 Technology Way Suite 210
(775) 684-5982

TUBERCULOSIS DISEASE TREATMENT AGREEMENT

I, _____, understand that I have been diagnosed with tuberculosis (TB) disease. My TB screening blood test (IGRA) or my tuberculin skin test (TST) result was positive at _____mm on ___/___/___. My chest x-ray is not normal and shows cavitary/non-cavitary (circle one) markings.

_____ I understand that treatment for TB is required according to Nevada Revised Statute 441A.180 and that I must follow all medical orders for the treatment of my TB. I understand that if I fail to complete my treatment it is a misdemeanor, for which I can be arrested and jailed to complete my treatment.

_____ I understand that I must not expose others to the disease as long as I am infectious. This means that while I am infectious, I must not go into enclosed public places where people are present such as work, school, church, stores, the movies or other people's homes. Also I must not have any visitors into my home.

_____ I agree to go to the TB Clinic every day during clinic hours without fail for directly observed therapy (DOT) which is the standard of care in Nevada. If I am infectious, the nurse will make arrangements for DOT in my home or designated residence while infectious.

_____ My medications started ___/___/___. The medications I will be taking are:

Isoniazid	_____mg	Ethambutol	_____mg
Rifampin	_____mg	Vitamin B6	_____mg
Pyrazinamide	_____mg	_____	_____mg

_____ I understand and will advise the TB Clinic / Case Manager if I have any of the following side effects occur.

☐ Nausea/vomiting	☐ Abdominal pain	☐ Jaundice skin/eyes
☐ Brown/dark urine	☐ Fatigue/weakness	☐ Numbness in hands or feet
☐ Decreased appetite	☐ Weight loss	☐ Joint pain

_____ I understand that Rifampin may also alter the effectiveness of birth control pills (consult your MD for alternative contraceptive), turn tears, saliva and urine orange in color and change the color of soft contact lenses (consult your specialist). I will report any of the following side effects:

☐ Bleeding/Easy bruising ☐ Blood in urine ☐ Flu like symptoms

_____ I will consult my doctor regarding any other medications I am taking, i.e., Dilantin.

_____ I understand that while on medication, it is important that I do not drink any beverages containing alcohol or take products containing Tylenol (acetaminophen), as these may damage my liver.

_____ I understand I should not become pregnant while taking TB medication and agree to notify the TB Clinic if I suspect I am pregnant.

My health care provider is _____. I understand I am required to have a Health Care Provider (HCP). If I do not currently have a HCP I will establish care with a provider within 30 days. If I have difficulty obtaining a provider, the TB Clinic case manager will assist with finding a provider.

Client signature: _____ _____
(Parent/Guardian for minor) Date

Witness Signature: _____ _____
Date